Baystate Health

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May 25, 2012

Áron Boros
Commissioner
Executive Office of Health and Human Services
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Subject: Testimony for Public Hearing on Health Care Provider and Payer Costs and Trends

Dear Mr. Boros:

In response to your May 9, 2012 letter, we have prepared the following written testimony. The deadline for providing a response to your letter was extremely short and some of the requested information was not readily available in the format requested. Accordingly, the testimony submitted below has been prepared based on reasonable inquiry and is true and correct to the best of our knowledge, information and reasonable belief.

Division of Health Care Finance & Policy Questions and Baystate Health (Baystate) Testimony

Hospitals & Other Providers

Trends in Premiums and Costs

1. After reviewing the preliminary reports, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.

   Due to the time constraints on our submission, as noted above, we have not had time to fully analyze and evaluate the preliminary reports.

   We note, however, that Baystate hospitals and other providers have a long standing commitment to quality and cost control. This approach and these efforts have contributed to Baycare being ranked in the preliminary reports as a lower relative total medical expense (TME) provider organization.

2. What specific actions has your organization taken to reduce the cost of services? Please also describe what impact, if any, these strategies have had on service quality and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?

Baystate has always focused on cost control. Many of the cost control initiatives we have implemented are detailed below. Our ability to effectively execute these and other cost control strategies is limited by our ability to fund operating and capital investments.

Some of our specific cost control initiatives are:

- Reduction in unit costs (Management of cost per unit of service delivered).
  - Consolidation of administrative and support functions where appropriate.
  - Supply chain initiatives (vendor pricing, supply standardization, etc.).
  - Pharmacy cost reductions (including utilization of the 340B drug pricing program).
  - Best practice functional benchmarking and productivity reviews.
  - Maximizing staffing efficiency by matching patient flow with nurse staffing requirements, etc.
  - Re-designation of Baystate Medical Center (BMC) with Magnet Hospital status for excellence in nursing in 2010. Only 2% of hospitals have received consecutive designations like BMC. Magnet status recognizes excellence in a variety of areas including nursing management, philosophy and practices, and adherence to standards for improving quality of patient care, which helps to reduce costs.

- Utilization management (Management of amount of services delivered per episode of care):
  - Through a physician directed approach, BMC has reduced unnecessary utilization while applying evidence based medicine to achieve high quality at low costs.
  - BMC has implemented a program to utilize hospitalists to better manage inpatient care in a cost-effective manner
  - BMC has employed physician directed performance improvement teams to review evidence, utilization data and create guidelines and decision support tools to drive quality and cost reduction.
  - Each year BMC benchmarks costs against 600 hospitals and sets specific goals to reduce overuse within the inpatient setting.
  - Baystate has been a leader in the use of Electronic Medical Record's (EMR) for many years which has resulted in increased reliability, quality and safety, and reduced unnecessary diagnostic testing. This has resulted in millions of dollars of reduced costs.
  - Related to EMR, we have achieved over 95% physician utilization of electronic order entry, which is among the leaders in the United States.
  - Baystate is employing LEAN thinking to reduce process waste through LEAN techniques.
  - BMC was designated as a 2010 and 2011 Leapfrog Group Top Hospital, putting the medical center in an elite group of the safest hospitals in the country.
  - BMC has been recognized for excellence in critical care by receiving a fifth Beacon Award, the only Intensive Care Unit in the US to have achieved this honor.

- Wellness programs, disease management and appropriate care setting (Development of programs for prevention and to properly match care needs to the proper setting and delivery of that care). Baystate is committed to improving health care delivery and providing programs and services that address the identified health and wellness needs of its constituencies and communities served:

- In the spring of 1996, BMC and other key stakeholders established Partners for a Healthier Community, a nonprofit organization committed to building a measurably healthier Springfield.
- In 2007, the Massachusetts Department of Public Health approved BMC's Determination of Need (DoN) application for its Master Facility Plan. In accordance with DoN Factor 9 requirements, BMC developed a plan to provide an array of new or additional community based services. BMC committed $9.6 million over a seven-year period or $1.3 million per year for the provision of health education and preventive health care services to improve population-based health in the project's service area. An additional $2.0M in funds has been committed related to BMC's emergency department expansion project.
- BMC's community outreach services include three full service community health centers and Western Massachusetts' largest Ob/Gyn clinic.

Baystate has taken proactive steps to improve the health of our employees through our Baystate Healthy wellness programs. Baystate Healthy includes health risk assessments, screenings and consultations, fitness, stress management, smoking cessation, nutrition/weight management, better sleep and other programs. Because we strongly encourage wellness, our health plans provide free well care visits.

3. When calculating Total Medical Expense (TME), we found a wide variation in health-status adjusted TME by provider group and that a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please share your organization's reaction to these findings.

   How health care services are delivered still is very much determined by the provider cultures and business practices that exist in the local markets. As those cultures continue to change toward one of integrated patient-centered care, and as business practices conform to consumer demands for fair and reasonable pricing and provider collaboration, we believe the variation in TME may diminish.

   Another factor that will help close the gap is patient education. Regardless of the published data on comparative quality, many patients continue to prefer receiving their health care from providers who have a reputation for higher quality. Many of those providers also have a higher TME. The perceived status of these providers has been long established, but until patients fully understand that similarly high quality care is available elsewhere, and they are comfortable receiving care elsewhere, the TME variation will exist. Even then, and even if they chose to, it may be difficult for patients to switch to lower cost providers while the primary care physician shortage persists.

   The preliminary report shows Baycare as a lower relative provider. This is consistent with the fact that Baystate has a long history of collaboration with other providers in our market. We recognize and respect what each of them has to offer the community and have not sought to undermine them for our own benefit. Rather, we continue to focus on what we do and how we can do it better and at a lower cost. We believe this approach and these efforts have contributed to Baycare being ranked as a lower relative TME provider organization.

4. Please explain the main factors for any changes in annual TME that your organization has experienced. What specific efforts has your organization made to lower or reduce the growth in TME? What has been the result of such efforts?

We continue to believe that changing the delivery system and payment methods/incentives is fundamental to achieving the triple aim of lower TME, higher quality and better patient experience. Therefore, our primary efforts have been directed toward further development of the patient-centered medical home, the clinical integration of services throughout the community, and risk-sharing contracts.

Baystate, Health New England (HNE) and Baycare Health Partners (Baycare®) already support eight fully functioning patient-centered medical homes with 25 practice sites, 17 of which already have achieved Level 3 NCQA recognition. Together, they care for approximately 30,000 HNE members and approximately 15,000 Blue Cross Blue Shield of Massachusetts members. Additionally, Baycare® is actively working with several other adult and pediatric primary care practices, the latter through the EOHHS' Patient-Centered Medical Home Initiative (PCMHI), to redesign their practices to become patient-centered medical homes.

Baystate, HNE and Baycare® are developing Information Technology and Analytic Reporting functions to provide actionable data for clinicians. In the case of HNE and Baycare®, a decision was made to use a common vendor, which resulted in lower purchase/implementation costs and will provide us with other cost savings benefits relating to standardization of data. We have also implemented an Integrated Health Care program using embedded Care Managers to better coordinate care and help patients in self-management and in care transitions. Further, Baycare is encouraging and disseminating Care Models to reduce variations in practice patterns based on consensus-adopted, evidence-based protocols (e.g., care models for lower back pain treatment and treatment of chest pain).

Concurrently, we continue to maintain a keen focus on reducing costs and avoiding redundancies throughout our integrated delivery system. For example, we have implemented a full-time LEAN Process Improvement program that resulted in first year savings of more than $3,000,000. We are in the process of implementing a financial improvement initiative to assess and identify areas where we could streamline processes and improve efficiencies.

In April, Thomson Reuters released the results of its most recent study of the healthcare industry. The study evaluates hospitals on measures of overall organization performance, including patient care, operational efficiency, and financial stability. BMC was again recognized as one of the top 15 major teaching hospitals based on the following measures:

- Risk-adjusted mortality index (in-hospital)
- Risk-adjusted complications index
- Risk-adjusted patient safety index
- Core measures mean percent
- 30-day risk-adjusted mortality rate
- 30-day risk-adjusted readmission rate
- Severity-adjusted average length of stay

- HCAHPS score (patient rating of overall hospital performance)

In addition, Thomson Reuters recognized Baystate as one of the top 15 integrated delivery systems nationwide, outperforming peers in a number of ways, including:

- Saving more lives and causing fewer patient complications
- Following industry-recommended standards of care more closely
- Making fewer patient safety errors
- Releasing patients half a day sooner
- Scoring better on overall patient satisfaction

It is difficult to determine exactly how much maintaining our focus on the things that result in achieving these recognitions has impacted TME, but we believe the impact is significant.

Health System Integration

5. How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.

   a. Is your organization participating in the Medicare Shared Savings ACO project?

   b. If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one?

Baystate, in collaboration with Baycare and the patient centered medical home practices, is planning to apply to become an ACO in the Medicare Shared Savings Program, and whether our accountable care journey culminates in a formal structure contracted through CMS or remains an ACO in the private sector, we have the leadership commitment, infrastructure and provider support to succeed.

Baystate is well positioned to provide high quality managed care through an organized, coordinated approach to population management that can provide a viable and sustainable path to controlling medical costs. BH includes three hospitals: BMC, an academic medical center, Baystate Franklin Medical Center and Baystate Mary Lane Hospital, community hospitals, which are focused on high quality of care. Drawing on the work of the Institute for Healthcare Improvement and Don Berwick, M.D., realizing the "Triple Aim" vision permeates our organization. BH has implemented several programs that have reduced readmissions, improved value through bundled care, and improved hospital quality and reduced complications.

HNE is an IPA-model HMO that started as a commercial insurer in 1985. Presently, Baystate owns 97% of HNE, which serves approximately 120,000 members in Western Massachusetts. HNE serves the (1) commercial market, including individual and small group products; (2) provides Medicare Advantage products to eligible individuals; and (3) as of July 1, 2010, provides coverage to MassHealth eligible individuals in Western Massachusetts through its HNE Be Healthy^{SM} managed Medicaid product. Consistent with its parent, HNE's mission is to serve all the people in Western Massachusetts through innovative and cost effective care management. The National Committee for Quality Assurance (NCQA) has ranked HNE one of the top ten health plans in the country.

Baycare® is a physician-hospital organization comprised of the three Baystate hospitals and about 200 medical practices in Hampden, Hampshire and Franklin counties. Our mission is to improve the quality, safety, efficiency and sustainability of health care in our community. Our proven clinical integration programs support and further this mission.

Critical to the success of patient-centered care and the transition from a fee-for-service to comprehensive payment model is the integration of health care across the continuum of the patient experience. Care must be better coordinated, rather than fragmented, as patients navigate through the various sites of care including pharmacies, physician offices, diagnostic & imaging centers, ambulatory procedure centers, acute care hospitals, and post acute facilities. Providers of care must collaborate to ensure the best outcome for their patients. Variations in practice patterns must be addressed to improve quality and reduce health care costs.

To this end, Baystate, HNE, and Baycare® collaborated to develop and implement an integrated health care model. Case and care managers from all three BH entities already cooperate in a number of ways, but this system-wide initiative has resulted in new and improved processes, systems, activities and models. These improvements better position us to deliver accountable care in the evolving health care environment. This multifaceted approach encompasses:

- *Population Management*: A series of activities performed for a population of patients including: health risk assessment, risk stratification and predictive modeling, registry assignment, outreach, and benefit plan design.
- *Care Models*: Condition- or disease-specific care delivery models developed through consensus and involving shared responsibility across providers.
- *Case Management*: The collaborative management of options and services available to patients with a high disease burden or those requiring high intensity of care and/or high cost care.
- *Care Coordination*: The intentional facilitation of care across the delivery continuum to ensure seamless value-enhancing transitions and a uniform care experience.

We are well positioned to assume a leading role in the accountable care arena. Our physician network encompasses a broad range of primary care and specialty physicians. Our Patient-Centered Medical Home (PCMH)/payment prototype positions us well to manage costs and quality under a comprehensive payment system. In addition to more than a decade of experience with embedded, practice-based care management, we have several years experience with measuring, analyzing, and communicating quality performance to our physician practices.

As providers prepare to transition from a predominantly fee for service world to global payments, we encourage the Commonwealth to consider ways to mitigate the potential provider risk associated with such payments, and avoid the disastrous consequences associated with previous experiments with alternative payment methodologies (i.e. capitation). For example, it seems reasonable to plan a transition period that affords enough time to make the necessary investments and modify provider and consumer expectations/behaviors to conform to a radically different delivery system and payment model. Also, while providers can take certain steps to enhance the likelihood of success in

an ACO and under risk (e.g. stop-loss insurance), it also seems reasonable to consider asymmetrical risk models that provide a greater upside (incentives) than downside, as risk is shifted from health plans to those providers.

6. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, patient outcomes and your organization's performance?

   BMC launched a bundled care prototype for total hip replacement patients on January 1, 2011. We are collaborating with HNE, New England Orthopedic Surgeons, and Baystate Visiting Nurse Association & Hospice to provide care for this patient population encompassing 30 days before to 90 days after the procedure. For calendar year 2011, we enrolled 45 patients in the 'bundled care prototype'. We have been able to lower costs by roughly $660 per patient while achieving 100% performance in surgery process measures. We observed improved patient satisfaction, no re-hospitalizations, and no patient harm, including no hospital acquired infections (urinary tract and surgical site), venous thromboembolism, or pressure ulcers.

   We are expanding our bundled care prototypes to 3 other populations including a chronic care model for asthma, total knee replacement and other elective surgical procedures.

   Baycare currently participates in risk-sharing contracts with HNE and BlueCross BlueShield of Massachusetts (the AQC). Both contracts include provisions for sharing surpluses and deficits, determined by comparing actual TME to a predetermined budget. Our financial performance to date has resulted in TME below budget and therefore the sharing of surpluses. On the quality side, we have achieved performance levels that earned the participating providers a high percentage of available quality incentive payments.

7. Please comment on how your organization is developing formal arrangements or affiliations with other health care providers to provide care under global contracts or other alternative payment methods.

   Under the bundled payment prototype discussed in question 6 above: formal agreements were entered into with the orthopedic surgeons and Baystate Visiting Nurse Association and Hospice to precipitate understanding of the arrangements, savings targets, and quality expectations.

   Regarding the Baycare risk-sharing contracts, we are working to develop a network of high-value providers to comprise a medical neighborhood that would support the patient-centered medical homes. We have engaged various providers in discussions about what they could do to help us lower costs and increase quality. To date, those providers include physician specialists, urgent care and post-acute care.

8. What have been the effects of the recent proliferation of limited or tiered network plans on your organization, with regard to how you evaluate performance internally and patient access to care?

   We are very concerned about the impact of limited and tiered networks on the community that we serve, and on our patients' ability to continue to receive their health care locally without being financially penalized. As the sole provider of tertiary care and other unique

services in western Massachusetts, Baystate is very sensitive to the cost and quality of our services. As the preliminary DHCFP report indicates, Baycare is a low relative TME provider organization. Yet, the methodologies used by some health plans to tier providers would indicate otherwise. For example, some plans compare unit costs (and disregard utilization) for a sample of services (e.g. hospital only), while others calculate TME (hospital, physician and all other providers). Also, some health plans compare hospitals on a statewide basis while others compare them locally and don't distinguish between teaching/tertiary care hospitals and community hospitals.

All of this results in confusion from the consumer perspective, frustration from the provider perspective, and a distorted view of actual provider performance. For example, provider A, who typically utilizes 3 units of a service at $75, is more costly than provider B, who can achieve the same results with 1 unit at $100. The health plan that tiers based on unit cost will place provider A in a more favorable tier than provider B. Conversely, the health plan that tiers based on TME will place provider B in a more favorable tier. The consequence of this is that patients may be directed away from less costly local providers to more costly providers further from their homes.

BMC is penalized by some plans because it provides tertiary care services, in addition to general acute care services, that tend to increase unit costs above those of the general acute care hospitals with which it is compared. If BMC were to discontinue providing tertiary care, it would compare very favorably with other local hospitals. However, the community would have to travel to central or eastern Massachusetts for tertiary care at hospitals that are significantly more expensive than BMC. That fact is not taken into consideration when most health plans assign tiers. Consequently, patients in need of those services are penalized with a much higher coinsurance or must seek tertiary care at a more favorably tiered hospital if they can even find one.

9. Given the proliferation of risk contracting, to what extent is your organization participating in global contracts that include "atypical" healthcare providers (e.g., behavioral health, oral health, home health care, etc)? If your organization participates in a risk contract, how are supporting services, such as behavioral health and home health care, addressed?

   "Atypical" health care providers are not included in our risk contracts. These providers are not treated any different from the legacy fee for service agreements with the health plans. However, since the providers participating in these contracts are at risk for most of the expenses of the atypical providers, our performance reports include the related utilization and we would address any material variances in either cost or utilization.

Health Care Quality

10. Are there specific areas of care for which you believe there are critical gaps in quality measurement?

    Current systems to measure hospital quality are lacking sophistication and sensitivity to be used for comparative purposes. They are limited to a few core "process" measures which are all now topping off at 100% thereby making every hospital indistinguishable from the next. In addition, hospital quality is measured using a few mortality measures which have already been demonstrated to be best for internal quality improvement work rather than for

hospital to hospital comparison due to numerous issues related to risk adjustment. Finally, an attempt to measure "harm" has been disappointing with current use of administrative data (HAC and PSI) showing poor positive predictive value and poor sensitivities.

New advanced quality measures are necessary to begin to reflect measures that matter to patients and measures that better assess "value" for healthcare dollars spent. These new measures need to be defined and pilot tested to help the health system evolve to a more integrated delivery system that delivers whole patient care. These new "whole system" measures are the next generation of quality metrics.

11. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

The current healthcare delivery system relies on many complex associations and relationships. BMC is not only the region's only tertiary academic medical center, it is a critical part of the Baystate regional integrated healthcare delivery system, which includes other less financially viable providers, including two community hospitals and primary care and specialty physician practices. We believe this integrated approach, as a whole, provides for higher quality care and better efficiencies for delivery of healthcare services in our region than could be provided by separate stand-alone providers. In the long run, quality and costs will be much better controlled through such systems.

We also recommend that government payers increase payment levels to cover costs of care so that the burden of the shortfall is not shifted to the commercial payers. In order to offset this payment shortfall we must negotiate higher payment rates from our non-governmental payers. Therefore, if the government payers would increase their rates to cover the costs and provide a margin for our ability to invest in new capital technologies, this would likely result in lower price increases to commercial payers.

Specific ideas to increase government payments include:

- Increase Medicare payment rates for certain outpatient services where payments currently do not cover costs
- Restore Medicaid reimbursement for graduate medical education.
- Begin Medicaid reimbursement for allied medical professional education.
- Ensure adequate and appropriate payment rates from MassHealth (e.g., Statewide Payment Amounts per Discharge do not correspond to current case mix) and Health Safety Net for services delivered by hospitals.

Other ideas for governmental intervention include:

- Develop and implement a statewide strategy to recruit primary care physicians and expend primary care capacity in the state.
- Address primary care access problems by encouraging alternative care sites and after-hours options to hospital emergency departments.

Attorney General's Office Questions
and Baystate Medical Center, Baystate Franklin Medical Center and Baystate Mary Lane Hospital's Testimony

1. For each year 2008 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

Baystate Hospitals & Physician Group				
Operating Margin (in millions)				
	FY 2008	**FY2009**	**FY2010**	**FY2011**
Governmental	($16.9)	($34.7)	($31.7)	($42.9)
Commercial	$54.9	$84.1	$72.1	$70.3
Other Business	$ 8.8	$14.9	$10.7	$ 1.6
Subtotal - Baystate Hospitals	**$46.8**	**$64.3**	**$51.1**	**$29.0**
Physician Group	($10.7)	($10.8)	($10.9)	($13.8)
Total Baystate Hospitals & Physician Group	**$36.1**	**$53.5**	**$40.2**	**$15.2**
Percentage of Total Business - Baystate Hospitals (Gross Revenue)				
	FY 2008	**FY2009**	**FY2010**	**FY2011**
Governmental	39.31%	39.68%	40.59%	39.96%
Commercial*	58.18%	57.63%	56.78%	57.20%
Other Business	2.51%	2.69%	2.63%	2.84%
Total	**100%**	**100%**	**100%**	**100%**

* Commercial includes Medicare HMO's, Medicaid HMO's, and Commonwealth Care plans that represent approximately 15% of our gross revenue that could also be considered as governmental.

The cost accounting system calculates the annual operating margin by patient and then aggregates all patients into their primary payor to determine a payor's operating margin. We calculate the expected reimbursement for each patient based on the services received and the associate primary payor's contract payment terms. We include both direct and indirect cost in our margin calculations. We include other operating revenue/non-patient revenue in our margin calculations.

Governmental Includes:

Mass Behavioral Health Partnership
Massachusetts Medicaid
Medicare
Out-of-State Medicaid

Commercial Includes:

Aetna Insurance
Blue Cross of Massachusetts
Boston Medical Center Health Net
CHAMPUS
CIGNA Health Plan
Commonwealth Care
CTCare of Massachusetts
Fallon Community Health Plan
GIC Indemnity Plan
Harvard Pilgrim Health Plan
Health New England
Neighborhood Health Plan
Network Health
Tufts Associated Health Plan
United Health Care
Various Automobile Insurance Plans
Various Other Commercial Insurance Plans
Various Workers Compensation Plans

Other Business includes miscellaneous transactions relating to both current and prior years.

Baystate Hospitals FY2011 Commercial HMO, PPO & POS Operating Revenue and Margin (in millions)		
	Revenue	**Margin**
HMO	$325.1	$27.2
PPO	$147.6	$35.8
POS	$ 18.8	$ 3.7

2. Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts (contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk), including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

The Baystate hospitals currently participate in three risk contracts, each of which provides for upside only sharing. One of the contracts does expose the hospitals to a potential loss of withhold, but because the number of patients under that contract is so small, which subjects the financial results to significant variability and little predictability; we have not invested specific additional resources to manage the risk.

If the hospitals do consider entering risk contracts that include material downside risk, they will work with Baycare®, the physician-hospital organization serving the three Baystate hospitals and over 200 medical practices with approximately 1,200 physicians, to quantify, analyze and help project our ability to manage that risk. Baycare has experience managing upside and downside risk contracts with two large commercial payors, and has developed an infrastructure that provides appropriate cost, utilization and quality reporting, along with medical director and business analyst resources to interpret those reports and help providers determine action plans to increase the likelihood of reduced costs and increased quality and patient satisfaction.

3. Please submit a summary table showing your advertising/marketing budget and costs for each year 2008 to present. Please explain and submit supporting documents that show the methodology you use to determine your advertising/marketing budget and costs.

Baystate Hospitals Expense (in millions)				
	FY2008	**FY2009**	**FY2010**	**FY2011**
Advertising/Marketing	$2.1	$1.7	$1.6	$1.9

Advertising/marketing budgets are determined on an annual basis based on consumer studies, community needs, and capacity issues. Based on input from community outreach, senior leaders, and clinical department heads, the budgets address the most critical marketing and communication needs of the hospitals. These needs include internal communications with over 10,000 physicians and employees. The results of these communication programs are reviewed and evaluated to insure that the goals being addressed were achieved in a cost effective manner.

4. Please explain and submit supporting documents that show (a) trends since 2008 in the proportion of bad debt, as defined by M.G.L. c. 118G, § 1, you carry on your total business, (b) your understanding of the factors underlying these trends in bad debt, including but not limited to any role of health insurance plan design, and (c) any changes you have made to your debt collection policies, practices, or expectations in light of these trends.

Baystate Hospitals & Physician Group				
	FY2008	**FY2009**	**FY2010**	**FY2011**
Proportion of Bad Debt to Total Business - Baystate Hospitals (Net Revenue)	1.65%	1.54%	1.36%	1.82%
Proportion of Bad Debt to Total Business - Physician Group (Net Revenue)	4.91%	3.97%	3.16%	3.25%
Proportion of Bad Debt to Total Business - Baystate Hospitals & Physician Group (Net Revenue)	2.02%	1.83%	1.58%	2.00%

In the 2008 to 2010 time period, bad debt trends were decreasing due to a combination of improvements in billing and collection related systems and processes, and increased insurance coverage.

During the 2010 to 2011 time period, we experienced bad debt increases, which we believe are due at least in part to increasing co-pay, deductible, and coinsurance amounts.

Because of recent trends, we are implementing increased point of service collections processes which require additional costs in terms of processes, systems, and staffing.

In closing, I am legally authorized and empowered to represent Baystate Health for the purposes of this testimony. I hereby certify under the pains and penalties of perjury that, under my direction, Baystate has made a diligent effort to respond to the foregoing questions, and that, to the best of my knowledge, information, and reasonable belief, the foregoing answers are true and correct.

Sincerely,

Dennis W. Chalke
Sr. VP, CFO and Treasurer, Baystate Health